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ABSTRACT

A series of discussions between the Gloucester (England) Health Authority and a research team resulted in a 3-year project designed to support elderly people, and those who care for them, in their own homes. This paper is an updated version of a discussion paper prepared during the formative phase of the project. It was created to encourage consideration of a number of key issues related to innovative programs for community care of the elderly. Included are discussions of the cost effectiveness of community care, the scope of community care, support for caregivers, care in and by the community, the domiciliary care/nursing interface, the need for psychogeriatric services, and the importance of diagnosis and reassessment. The paper concludes with a brief consideration of the nature and problems of evaluation. The conclusion notes that subsequent evaluation will focus on the effect of improved needs assessment and coordination of service delivery on the maintenance of elderly people in their homes, and on their quality of life and well-being. Also evaluated wil be the initial definitions of at-risk clients; the new tools for needs identification, biographical analysis, and the assessment of consumer satisfaction developed during the course of the project; and the economic implications of the provision of care coordinators posts. (NB)

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CARE FOR ELDERLY PEOPLE IN THE COMMUNITY
A Review of the Issues and the Research*

by
Michael Carley, Tim Dant, Brian Gearing
and Malcolm Johnson**

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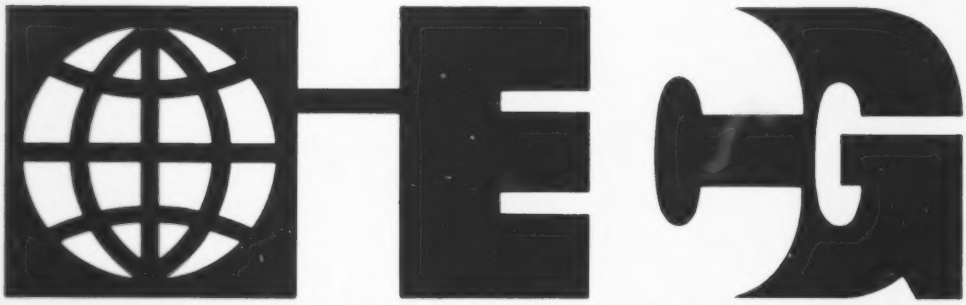

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*from Care of Elderly People at Home, a research and development project published by the Open University Department of Social Welfare and Policy Studies Institute, in collaboration with the Gloucester Health Authority

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CARE FOR ELDERLY PEOPLE AT HOME

- A SERIES OF PROJECT PAPERS

This is one of a series of Project Papers arising out of the Care For Elderly People at Home project being conducted in collaboration with the Gloucester Health Authority by a research team led by Malcolm Johnson, Professor of Health and Social Welfare at the Open University. The other members of the Research Team are Michael Carley (Research Fellow, Policy Studies Institute), Brian Gearing (Lecturer, Open University) and Tim Dant (Research Fellow, Open University but based in Gloucester for the project). The project is funded by the Gloucester Health Authority and the Nuffield Provincial Hospitals Trust. It began in June 1986, the first year being an initial phase of planning, experimenting and setting up and will finish in May 1989.

Gloucester Health Authority, faced with changing perceptions of the health needs of elderly people and an increase in the number of elderly people in the local population, decided to look for innovative ways of helping elderly people in the community. It was felt that new ideas were needed about how best to provide services that would help elderly people remain in their own homes. The Health Authority sought the collaboration of academic experts in the fields of social welfare and evaluative

research to help with the development of health services appropriate to the needs of elderly people. A series of discussions were held between the Health Authority and the research team. These led to proposals being considered and approved in October 1985 by the Health Authority, for an experimental service development linked to an evaluative research project.

A main assumption of the project is that many of the specific problems of frail elderly people living at home are related to physical disorders and mental disorders including memory-impairing disease. In so far as these are health problems, many are either treatable or can be managed in the home. But for elderly people in particular, health problems are intimately tied in with their social situation and needs cannot be simply categorised as 'social' or 'medical'. When people are at risk of no longer being able to cope in their own home they need a range of help covering a set of needs, both medical and social, that are particular to each person.

The service innovation in Gloucester is based on the provision of key workers, called Care Co-ordinators, attached to three primary health care teams (PHCTs).

There are three aspects to this role:

1) Gathering and exchanging information on services and resources available locally that may help elderly people to remain in their own homes for as long as possible.

2) Assessing the individual needs of elderly people who are patients of the practice and assisting in meeting those needs.

3) Gathering information for research purposes both on the effect of services on individuals and on the general availability and appropriateness of services.

The Care Co-ordinators work as a members of the PHCTs. They receive referrals of individual cases from other members of the team and share the specialist knowledge they are gathering on local facilities with them.

An innovative feature of the project is the use of a 'biographical approach' to assess the needs of individual elderly people. By trying to understand people's current needs in a context of their past experience it is hoped that there will be an improvement in the appropriateness and acceptability of services offered. The meetings that involve gathering biographical information will lead to an initial assessment of the elderly person's needs. The needs that the Care Co-ordinator tries to meet will first of all be agreed with the elderly person and any carers who are involved. It is anticipated that a refinement of this technique will be developed during the life of the Project so that it can become a tool for practitioners to be used in conjunction with the Checklist (see below).

On the basis of the agreed needs the Care Co-ordinator will set up a 'package of care' that links statutory, voluntary and informal services to enable the elderly person to

remain at home. Such a package may include nursing services, meals on wheels, home care services, day care and other provision as well as 'buying in' informal care. An important part of co-ordination would be to link such services with care being provided by relatives, friends and neighbours.

It is hoped that use of the biographical approach, together with the active co-ordination of a package of care services by the Care Co-ordinator, will foster independence and reduce the risk of elderly people being taken into institutional care.

In addition to information from the biographical interview, the Care Co-ordinators will use a 'checklist' to keep a systematic record for monitoring the effectiveness of support. As well as being a device for reviewing work done with individuals, the checklist will provide information for use in evaluating the effects of having Care Co-ordinators in the community. The changes in the use of services by individuals will be monitored together with the effectiveness of those services in helping people remain at home.

It is anticipated that the role of the Care Co-ordinator will develop differently in the context of the three different areas and professional teams they are working in. Another component of the evaluation will be to study the style of primary health care delivery in the three study practices and compare it with the style of delivery in other volunteer 'contrast' practices. There will also be

studies of the satisfaction of users, carers and co-workers with the service development.

This first in a series of Project Papers was originally prepared for the District Management Team of the Gloucester Health Authority. Its purpose is to encourage consideration of a number of key issues related to innovatory programmes for the community care of elderly people.

June 1987

INTRODUCTION

A series of discussions between the Gloucester Health Authority and the research team recently resulted in a three year project designed to support elderly people, and those who care for them, in their own homes. A central feature is the provision of care co-ordinators attached to three primary health care teams. A main assumption of the project is that many of the specific problems of frail elderly people living at home are related to physical and mental disorders, memory-impairing disease, or social situation, and that problems which may lead to loss of functional ability are either treatable or can be managed in the home. The provision of accurate socio-medical assessment by the primary health care team (PHCT) is central to the project. This is the prerequisite to the creation of a personalised package of care services by the care co-ordinator, which are intended to reduce the risk of loss of independence.

This paper was prepared originally for the District Management Team of the Health Authority as a discussion paper during the formative phase of the project. It has now been updated. Its purpose is to encourage consideration of a number of key issues related to innovatory programmes for community care of elderly people. The main themes of the paper are: the cost effectiveness of community care, the scope of community care, support for carers, care in and by the community, the domiciliary care/nursing interface, the need for psychogeriatric services, and the importance of diagnosis and re-assessment. The paper concludes with a brief consideration of the nature and problems of evaluation.

COST EFFECTIVENESS AND COMMUNITY CARE

The general case for community care has been well explored elsewhere. Community care in this paper is taken as any programme or service which provides support to the elderly living at home, and which is likely to postpone or obviate the need for long-term residential care(1). Issues related to long-term residential care and/or sheltered housing are not examined, but have been reviewed elsewhere(2). Research on the cost effectiveness of community care is scarce, but what is available suggests it is less expensive than long term institutionalisation and therefore meets not only social and psychological objectives but may be a reasonable direction into which to deploy resources.

Recent DOE research(3,4) puts costs per annum of all forms of state support (including supplementary pension and attendance allowance) to a highly dependent person as follows:

	£
Hospital	
acute	20,319
long stay	15,347
geriatric	14,814
Part III Residential Homes	5,953
Local Authority Sheltered Housing	4,940
Innovatory Schemes	
Home carers	6,610
Home care assistants	4,716
Emergency Telephone Service	4,234
Neighbourly helps	4,222
Visiting wardens	4,080

The DOE report concludes that while innovatory community care schemes plus statutory services are not a cheap option when all public costs are considered, they are generally cheaper than the alternatives. The majority of studies come to the same conclusion: for all except some very disabled persons, the cost of community care is less than institutional care. A number of studies report significant savings in the prevention of hospital admissions, and evidence of rehabilitation and higher survival rates(5). Social benefits, summarised for the King's Fund(5), may include increased morale, decreased loneliness, improved health, increased mobility, reduced dependence, increased social contact, and increased capacity to cope. A study of augmented home nursing as an alternative to hospital care for chronic elderly invalids in North Tees Health District concluded 'the cost of such care is cheaper than keeping the patient in hospital ... and might reduce the need for long stay geriatric beds'(6). Exceptions to these conclusions are reported only where the costs of community care have been difficult to assess, where there is poor provision of domiciliary care, or where an old person lives alone and needs 24 hour assistance to function at home(7,8).

THE POTENTIAL SCOPE OF COMMUNITY CARE SCHEMES

Two major surveys of elderly persons, 65 years of age and over(9), and 75 years and over(10), indicate that, whilst the indoor tasks of domestic living are successfully carried out by the large majority of older people living at home, the numbers with

health-related problems which reduce mobility and self-care capacity rises considerably after age 75. To take just two examples of many basic living incapacities: one might estimate from studies that the proportion of the over-75s in the Gloucester area who are unable to bath themselves unaided would be around 35 per cent whilst an even larger percentage would not be able to cut their own toenails.

Widespread needs of this kind may not always be considered as serious a focus for a health authority's community programme as illnesses which have typically resulted in skilled medical attention or hospitalisation. But they do affect the ability to live independently and reasonably comfortably in the community and, moreover, are often related to progressive illness conditions, like arthritis, which can be alleviated.

This raises a basic question about any attempt to assist older people to remain at home. Would such an effort include such widespread needs which are both health-related and require human assistance but do not require continuous medical or skilled nursing intervention? The implications are that to cope with needs on this scale a health authority would have to: (a) define the aims of its community care programme broadly, in terms of the provision or organisation of practical support to incapacitated older people, rather than more narrowly in terms of just the crisis-care or long-term care of the sick; (b) identify the overall need for such support and how it could be delivered to those in need; (c) plan for a high degree of joint health and social services provision; (d) be confident of the possibility of involving voluntary and neighbourhood care agencies; and (e) have the resources to do all this.

It was important in planning the Gloucester project to clarify at an early stage what the Health Authority foresaw as being achieveable given their resources and general terms of reference for the study and subsequent programme. It was also necessary to clarify whether the study was to be directed mainly to finding alternatives to institutional care for those who become very ill and incapacitated, for example, a hospital at home programme; or in devising a more comprehensive support service for older people with varying levels of incapacity, for example as might be provided by a home carer.

WHICH ELDERLY PEOPLE ARE AT RISK?

An obvious and supportable approach for any community care intervention would be to focus on those persons 'at risk' or on the margin of need for residential care, and

these people are most often the focus of innovatory schemes(5,11,12). The DOE study concluded that 'priority should be given to the very dependent, those living alone, the over-75s, the confused, and to back up families caring for elderly relatives'(3). However this list constitutes a fairly broad group and may need to be further refined if realistic pilot projects for assisting elderly people to remain independent are to be identified.

Bergmann and Jacoby(21) suggest a public health approach to the problems of the elderly, with screening and assessment of vulnerable groups. They define these vulnerable groups from epidemiological and other research as:

i Older people over 75 years of age and living alone.
ii Older people recently bereaved.
iii Older people recently discharged from hospital.
iv Older people requiring home help and community services.
v Older people asking for residential care.
vi Older people planning to give up their own homes for any other reason.

However, two points are worth stressing. First, multiple indicators from the above list may be necessary to define manageable numbers of elderly people at risk and in need of social intervention. Second, single innovatory schemes by themselves may be insufficient in sustaining an elderly person at home(3,13). What may be required is a carefully thought-out package of services designed to fit the particular needs of the elderly person. This requires knowledge and coordination among a range of statutory and informal support services, and suggests the importance of individual diagnosis and periodic reassessment.

SUPPORTING THE SUPPORTERS

Extensive research substantiates the view that the most valuable community resource is the help given the elderly by their families, and one of the clearest limitations to the extent of such care is the stress this situation imposes on caring relatives. Bergmann and Jacoby's survey(21) found that although the supporters interviewed wished to care for their older persons, three quarters expressed moderate or severe distress at what they had to do. Thirty-five per cent of supporters scored at a level on the General Health Questionnaire(14) at which there is a high probability that the respondent would be assessed as needing psychiatric care. Other studies have suggested that lack of respite or relief from the caring role is the greatest burden of caring. Levin(15) found that about 50 per cent of her respondents living with an elderly person could not leave them alone for three hours without anxiety, and 25 per cent <u>never</u> left the elderly person alone.

Allen(17) found that 75 per cent of dependent elderly had not been away from their carers overnight in the last year, except in a short stay residential home. She concludes that the short stay respite was a lifeline, without which there was little doubt that some supporters would have been unable to continue their caring role.

Many studies have highlighted the degree of physical and psychological stress felt by family carers. Particular attention has been drawn to the poor health of carers, financial costs, social isolation, lack of relief, disruption of family life and erosion of privacy(18,19). Of particular interest for programmes aimed at the elderly on the margin of residential care is the question posed by Allen(17): why do carers give up? The most common answers are faecal incontinence, sleep disturbance, and behavioural problems, particularly aggression and wandering and shouting(17,20).

It may well be therefore that some pressure on geriatric units might be reduced, and waiting lists shortened, if more adequate attention were paid in the community to the supporters of disabled older people. The important point is that studies do demonstrate that relatively straightfoward community services - like a night-sitter service would, if provided in time, relieve the strain and often prevent breakdown on the part of the carer. Unfortunately, help (in the form of removal from the community) too frequently arrives after a crisis, resulting in institutional care. At issue is how to ensure that the most appropriate support for family care givers is provided at the time they need it. 'Appropriate' support may particularly take the form of day care, relief admission, home help and nursing services. However, limitations in the provision of these services have been identified(21). First, GPs were found to be the 'gate-keepers' to services, but varied in their capacity to act on social, as well as medical, need(22). Second, professionals do not always have the appropriate skills to address these problems. Third, services may be simply in short supply in particular areas.

With regard to respite care for supporters, the options are day centres and day hospitals for a few hours of relief; and short stay placements in residential homes, to allow carers to take holidays or have medical treatment themselves. The findings of the first round of evaluative studies on respite care are salutory, with researchers in unison saying that it provides much needed relief and freedom for care givers(23,54). However, the short-term residents themselves may have unsatisfactory experiences. Both Allen(54) and Oswin(24), whose studies looked respectively at homes for old people and for mentally handicapped people, reached a common conclusion: that short term placements in establishments which were the long term residences of others were an intrusion and a disruptive element.

Day care is another facility which allows simultaneous care for the elderly person and relief for the carer. However, studies of day hospitals and day centres consistently point to problems of transport, long journeys, and unpredictable departure and return times. Fennell et al.(25) on day centres and Smith et al.(26) on day hospitals show how organisational requirements and staff practices often result in returned attenders who are tired and difficult because of an arduous and relatively unstimulating, but anxiety ridden day. Nevertheless, it may be that some measure of discomfort for the elderly person may need to be tolerated, to gain the substantial advantages of respite care, and to forestall the case where the carer can no longer cope.

CARE BY THE COMMUNITY

Care in the community by family is quite different from care by the community. Salvage(5) describes the latter as 'a much more nebulous concept which implies that ... neighbours, volunteers, voluntary organisations, and formal and informal support networks assume ... responsibility for many kinds of care and assistance'. Innovatory programmes of this type attempt to postpone admission to residential care by relieving pressure on carers, and involve employment of individuals who fulfil roles similar to conventional home helps but extended to more personal tasks and, in some cases, basic nursing tasks. The Association of Crossroads Care Attendant Schemes(27), for instance, have succeeded in merging roles of home help and nursing auxiliary in providing for the physically handicapped at home, and are certainly the most successful of the care by community approaches(20).

Whilst the current wisdom is that neighbourhood care should 'mesh in' or interweave with informal and statutory care, the achievement of this in practice is complex. The issues here are: the question of the recruitment, organisation and monitoring of volunteers; the fostering rather than taking-over of neighbourhood schemes by professionals; adequate support for non-professional helpers; token payments to or some recognition for volunteers or neighbours (as in many street warden schemes); and the question of larger task-related payments to non-professional carers, as in the Kent Community Care Scheme(11). On the latter point, MacLennan et al(28) note that care by 'neighbours seemed much less effective than relatives in general. The situation might be different if neighbours were given specific duties and a payment were made'.

DOMICILIARY CARE/NURSING INTERFACE

A clear conclusion from a review of the research literature is that, just as the critical target of care may be the 75+ age group, so the most productive community care occurs at what Salvage(5) calls the domiciliary care/nursing interface. This area could therefore receive priority in resource allocation to innovatory projects and relates to findings(29) that at least some of institutionalised elderly persons are capable of living in the community, if increased domiciliary and home nursing care is available. Wade et al.(30) report that interviews with elderly persons being maintained in the community have showed quite clearly that the services of community nurses and home helps were the most appreciated. The Personal Social Services Research Unit Sourcebook(31) on innovatory care for elderly persons reports that much of the best innovation within the NHS is towards greater numbers and new patterns of deployment of community nurses and community psychiatric nurses. These are variously based in hospitals, primary health care teams, or even attached to Social Service Department teams. Batchelor(32) in his recent review for the Nuffield Provincial Hospitals Trust, recommends that enrolled and auxiliary nurses and psychiatric nurses should undertake a much greater share of the delivery of community care. He also suggests that the respective roles of district nurses and health visitors be clarified.

The likely 'balance of care' in these situations will depend entirely on the particular arrangements in any locale among the Social Services Department, the Health Authority, and voluntary agencies. This is clearly an area where the possibilities for joint cooperation and interdisciplinary team work need to be assessed. In the North Tees Health District study(6), for example, the project team included a physician/geriatrician, a GP, a senior nursing officer, a social worker, a community services administrator, a home help organiser, home nursing officers and sisters, and a number of others. There are many other examples of such joint approaches, and their potential for providing excellent home care and deferment from institutions is substantial. Indeed, lack of provision in one sector, say of home helps, can well result in a misuse of places in another, say bed spaces in hospital(33).

However substantial the potential benefits of multi-disciplinary working, the evidence is that concrete achievement of joint care, planning or finance are difficult to obtain, and the impediments should not be underestimated. Rhodes and Green(34) sum up the major problems as: differing priorities, different views about the nature of problems and how to solve them, different ideas about the division of

responsibilities, and lack of resources to pursue joint care. In addition, each local situation tends to be organisationally unique, and the individual 'personalities' involved are a surprisingly important factor. Therefore replication of successful joint planning/care is difficult. Rhodes and Green(34) comment that:

> One of the reasons suggested by investigators for the disappointing results produced by joint planning is that naive assumptions have been made about the ways in which professions and organisations work together. It has often been assumed that the patients were the first concern and that, as a result, agreement would emerge from discussion. There are examples of successful collaboration on small matters. But on larger issues affecting the size of the budget, the demand for more staff, or where different professions took different views about what type of care was appropriate, then officials acted more as 'negotiators or protagonists' than as colleagues.

Nevertheless, where there have been improvements in services to the elderly these have been in shifts away from institutional care and towards earlier discharge, basic nursing care, and multi-disciplinary assessment and care(13). Bayley's(35) work in Dinnington suggests that greater integration of services in the field is dependent on closer collaboration at managerial levels. Ferlie et al.'s(13) findings on innovation in the NHS suggest the same. The following points may be helpful in promoting joint care: modified professional training to reduce divergent outlooks, increased joint in-service training, and increased locally based teamwork(34).

PSYCHOGERIATRIC SERVICES

Mentally infirm old people probably constitute the biggest challenge to any community care policy. Roughly 1 in 5 of old people over 80 (the segment of the aged population which is increasing) suffer from dementia and pose particular problems for themselves and caring families. Though dementia of the Altzheimer's type is at present incurable, other mental and physical conditions which are sometimes mistaken for dementia can be alleviated. A major issue for the study has to be what kind of psychogeriatric service can be provided to help older people and what support can be given to families who look after them.

The DOE report(3) states that 'one of the greatest problems caused by the growing bulge of very elderly people will be a matching growth in confusion and dementia' and notes that confused people in residential care may cause intense upset to other residents. MacLennan et al.(20) concluded from their research on medical and social factors influencing admission to residential care that any reduction in admission would require 'a psychogeriatric service effectively orientated towards community support'. This is defined as support and follow-up by community

psychiatric nurses, active psychogeriatric day hospitals, and a rapid response to crisis by short-stay admission to hospital. As mentioned, many of the innovatory NHS schemes reported in the PSSRU Sourcebook(31) involved the placement of psychiatric community nurses with primary health care teams or joint assessment and care teams.

'BUYING-IN' OF INFORMAL CARE

Budgets for buying-in informal care, where existing provision is not appropriate to client's needs, have been the central focus of two similar projects: the Kent Community Care Scheme(47) and Guy's Hospital/Age Concern Home Support Project(48). The former project made use of a social service department allocated budget to maintain frail elderly people at home at the point when they otherwise would have been institutionalised. The Guy's Hospital Project bought in support workers to maintain elderly people with dementia at home. The support workers in both cases were local people (almost always women) who lived within walking distance of the client, and were paid at about the standard care attendant rate for the work. Murphy and Rapley call this 'a good neighbour recruitment policy' and note that carers usually developed close working relationships with the elderly people. The Guy's Hospital project determined that such care was usually cheaper than residential or hospital care up to the point of about 35 hours provision per week.

DIAGNOSIS AND REASSESSMENT

Underlying the move towards community care is the knowledge that too often expensive resources are ill-matched to client needs. Either a service is not given when needed, or conversely an inappropriate service is given or continued when it is not needed(36). The most common cause is poor or superficial diagnosis and a lack of follow-up reassessment. The contribution of accurate medical diagnosis to physical well-being is obvious, but the equal importance of the assessment of social needs and the background social situation is often underestimated. Such social needs may relate both to the condition of the elderly person and to the situation of the supporter.

A first step in assessment is sometimes the multi-dimensional self reports designed to measure physical, emotional and social function(37). This material is supplemented by in-depth interview and visits to relatives and carers. This may require considerable staff training to give the skills to carry out a careful and compre-

hensive assessment(38). MacLennan et al.(28) describe the procedures used in a project to assess female clients whose physical and social disabilities place them close to the boundary between domiciliary and residential care:

> A community nurse visited all potential subjects to seek their consent to participation and used a proforma to collect details on their social background. On a subsequent visit a doctor took a structured history, which included information on mobility and the ability of the woman to take care of herself, and performed a physical examination, which included an assessment of visual acuity, skinfold thickness, and sway. Two simple questionnaires were used to quantify mental status and depressive symptoms.

Good assessment, as good care, is often a multi-disciplinary activity. Ferlie et al.(13) find that assessment procedures are improved by consultation between geriatrician and pshychogeriatricians, which is vital in view of the overlap between physical and psychiatric morbidity. However, as in joint care, joint working is no panacea. Capenter and Paley(39), in a structured team reassessment of 80 cases receiving domiciliary care, found a significant disagreement about assessment in 39 per cent of the cases. There appears to be no set solution to intractable hinderances to assessment, but the importance of accurate assessment, and periodic reassessment at appropriate intervals, is obvious.

One manner of addressing problems involving coordination of skills and resources is the care coordinator or key worker approach(31). This involves a single person who acts as point of contact for the client, consults a multi-disciplinary team, devises an individual care package, and takes responsibility for its implementation. Despite the problems endemic in multi-disciplinary working (bureaucratic separation of resources, professional boundaries and divergent views, etc.) it is an approach worth striving for, especially in the case of frail or disturbed elderly persons who require a broad range of interconnected services if they are to avoid or leave hospital. Ferlie et al.(13) find that the success of innovatory NHS schemes in terms of higher turnover rates are strongly 'associated with multi-disciplinary working and deployment of a wide range of community based workers'.

As described, the care co-ordinator approach provides the basis for the Gloucester project. Those people identified by PHCTs as requiring further assessment will be visited by a care co-ordinator, who will undertake physical and psycho-social assessment, as well as conducting a biographical analysis. A variety of assessment tools are being examined. The assessments will assist the care co-ordinator and the PHCT in putting together the package of services required to maintain the client at home, and will also allow measurement of life functions for evaluative

purposes. A separate working paper on screening, assessment, and biographical analysis is being prepared by the research team.

EVALUATION AND COMMUNITY CARE

Evaluation is undertaken to provide feedback to assist better decisions on management objectives and resource allocation. Evaluation provides an opportunity for detailed task analysis which demonstrates the relative effectiveness and/or efficiency of different approaches to service provision.

The problems of social evaluation generally, and with regard to the elderly, have been discussed at length elsewhere(40,41,42). The general consensus is that social evaluation will not and cannot optimise resource decisions, but that two useful evaluation approaches may be considered. The first group comprises experimental and especially quasi-experimental approaches which generally test the relative effectiveness of specific intervention programmes or service delivery systems. This is usually done by comparing the success of new service A for a clearly defined geographical area or target group to older service B. The change in service delivery may be in programme content, assessment procedure, or other management alteration. Within this are more or less formal cost-benefit approaches which assess opportunity costs and shifts in the balance of care which might give better value for money(43).

Some researchers argue that a close approximation of the classic experimental framework (or randomised control trial) is the only way to test the efficacy of intervention, and that evaluators should aspire to this model(49). Such an experimental test consists of a 'before and after' comparison of two equivalent groups of people, one of whom has been subject to the intervention while the other has not. If all other factors are equal, that is, have an identical effect on both groups, then any differences between the two groups may be attributed to the intervention. Illsley(50) specifies minimum criteria for this evaluation model:

(i) The primary objective of the intervention can be unequivocally specified;

(ii) It tests the effectiveness and/or efficiency of a given product or processes in achieving the goal compared with alternative interventions or with no intervention;

(iii) It has a precise foreseeable and measurable control over the nature and quality of the input;

(iv) Influences extraneous to the measured input, the controlled intervention process and the measured output can be excluded by research design;

(v) The criterion of success is uncontroversial and can be measured in a single dimension.

In terms of the above criteria, problems in assessing community care interventions arise with points (ii) to (v). First, to test 'no intervention', requires assignment of clients to either an experimental group receiving identical interventions or to a control group receiving none. The clients assigned to these groups must match closely in terms of age, sex, social class, marital status, living circumstances, income, housing conditions, nature and severity of disability, and social interactions such as contacts with family and neighbours. If such matching does not occur, conclusions may be suspect.

Criteria (iii) requires that an intervention be the same with each client. However, the interventions in community care often cover a continuum of care possibilities or packages and it is likely that members of primary health care teams will make use of feedback of intermediate results to alter practice, where social conditions can be affected by PHCT action. As well, clients are known to respond as much to the manner of a person intervening as to the intervention itself.

In terms of (iv), it may be difficult or impossible to control clients' social situation or 'intervening variables' such as the nature and quality of other statutory or informal care(51). Finally, in terms of (v), Smith and Cantley(52) suggest there may be multiple definitions of project success, that is, health authority staff, care coordinators, GPs, clients, informal carers and others may have differing views abut whether the project is successful. This view is echoed by Wilkin(53). In a study of short-stay residential care, Allen(54) notes that what is seen as a benefit by informal carers may be viewed as an unpleasant and unnecessary experience by elderly persons.

A quasi-experiment will not paint the whole picture of project worthiness. Wilkin (1986), for example, stresses that in primary health care research it is important that evaluations make use of objective and subjective measures of outcome, observational material, and that attention is paid to structural factors, such as housing, as well as to care provision.

For these and other reasons, some researchers suggest that the numerous difficulties facing the experimental model of evaluation may be almost impossible to overcome where an intervention may be both medical and social(52). In this case it is argued that such evaluations do not give good value for money because the many difficulties invariably result in either very tentative or suspect conclusions. Instead a second model of evaluation is proposed. This is 'pluralistic evaluation' which is characteristed by concern for:

a) institutional functioning;
b) monitoring of project implementation and client characteristics;
c) the subjective views of major constituent groups as to project success;
d) methodological 'triangulation' by which a variety of data sources are used to judge project worthiness; and
e) quality of service to clients.

There is something to both sides of these arguments, and it may be the case that there is no one 'right' answer about how to evaluate projects concerned with social functioning of elderly people in their homes. The pluralistic approach, in its concern for project implementation, organisational supports and constraints, and multiple views of project success, has much to commend it. However, it lacks a necessary comparative framework. Therefore a comparative approach with systematic monitoring of client experience and project implementation may be useful. The aim of monitoring is to discover how services and resources including professional skills are used in relation to different problems presented and aims pursued. As Goldberg and Connelly(41) put it, a monitoring system should inform policy and practice by eliciting trends in client characteristics, problems presented, help requested, services responses, and broad achievement of objectives. Monitoring itself is feedback of information and therefore requires the resources and the authority to collect that information. Better still may be action research which links information flows to feedback to the field level, and to commitment to change programmes.

CONCLUSION

For the three-year Gloucester project it has been decided to combine an action research emphasis in the early stages with a more systematic evaluative framework to be implemented during the latter two years of the project. In particular the action research perspective allows an incremental refocussing of the project, an important point in the initial stages where the care co-ordinators have been

'fitting-in' to the PHCTs, and learning a new range of skills in needs assessment with the help of the research team. In addition there has been considerable 'learning-by-doing' on the part of the care co-ordinators in assessment and counselling with elderly clients. The early experience is that a commitment to the action research approach allows unanticipated issues to be dealt with promptly and profitably, and that attempting to hold the nature of the intervention constant over the course of the project would have been unproductive and perhaps unacceptable to the three PHCTs. This flexibility is one advantage of action research.

Subsequent evaluation will focus on the effect of improved needs assessment and coordination of service delivery on the maintenance of elderly people in their homes, and on their quality of life and well-being. The working arrangements of contrast practices, without the possible benefit of care co-ordinator activity, will also be examined with regard to care for elderly clients. Finally, the project will also evaluate the initial definitions of 'at risk' clients; the new tools for needs identification, biographical analysis and the assessment of consumer satisfaction developed during the course of the project; and the economic implications of the provision of care co-ordinators posts. Later research papers in this series will describe the action research experience and the evaluation in more detail.

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